



St. Dominic Home Health Care, Inc.

720 W Cheyenne Ave. #210, North Las Vegas, NV 89030-7847
Tel (702) 473-9594 ♦ Fax (702) 473-9595

Employment Application Form

PLEASE PRINT ALL
INFORMATION REQUESTED
EXCEPT SIGNATURE

APPLICATION FOR EMPLOYMENT APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS

PLEASE COMPLETE PAGES 1-5

DATE: _____

NAME: _____
LAST FIRST MIDDLE MAIDEN

PRESENT ADDRESS: _____
NUMBER STREET CITY STATE ZIP

HOW LONG: _____ SOCIAL SECURITY NO. ____ - ____ - _____

TELEPHONE () _____

IF UNDER 18, PLEASE LIST AGE _____

POSITION APPLIED FOR (1) _____
AND SALARY DESIRED (2) _____
(BE SPECIFIC)

DAYS/HOURS AVAILABLE TO WORK
NO PREF _____ THUR _____
MON _____ FRI _____
TUE _____ SAT _____
WED _____ SUN _____

HOW MANY HOURS CAN YOU WORK WEEKLY?

CAN YOU WORK NIGHTS?

EMPLOYMENT DESIRED: FULL-TIME ONLY PART-TIME ONLY FULL-TIME OR PART-TIME

WHEN AVAILABLE FOR WORK? _____

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (COMPLETE MAILING ADDRESS)	NUMBER OF YEAR COMPLETED	MAJOR & DEGREE
HIGH SCHOOL				
COLLEGE				
BUS. OR TRADE SCHOOL				
PROFESSIONAL SCHOOL				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? NO YES

IF YES, EXPLAIN NUMBER OF CONVICTION(S), NATURE OF OFFENSE(S), LEADING TO CONVICTION(S), HOW RECENTLY SUCH OFFENSE(S) WAS/WERE COMMITTED, SENTENCE(S) IMPOSED, AND TYPE(S) OF REHABILITATION. _____

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APPLICATION FOR EMPLOYMENT

WORK EXPERIENCE: PLEASE LIST YOUR WORK EXPERIENCE FOR THE PAST FIVE YEARS BEGINNING WITH YOUR MOST RECENT JOB HELD. IF YOU WERE SELF-EMPLOYED, GIVE FIRM NAME. **ATTACH ADDITIONAL SHEETS IF NECESSARY.**

NAME OF EMPLOYER: _____ ADDRESS: _____ CITY, STATE, ZIP: _____ PHONE NUMBER: _____	NAME OF LAST SUPERVISOR	EMPLOYMENT DATES	PAY OR SALARY
		FROM: _____ TO: _____	START: _____ FINAL: _____
YOUR LAST JOB TITLE: _____			

REASON FOR LEAVING (BE SPECIFIC):

LIST THE JOBS YOU HELD, DUTIES PERFORMED, SKILLS USED OR LEARNED, ADVANCEMENTS OR PROMOTIONS WHILE YOU WORKED AT THIS COMPANY.

NAME NAME OF EMPLOYER: _____ ADDRESS: _____ CITY, STATE, ZIP: _____ PHONE NUMBER: _____	NAME OF LAST SUPERVISOR	EMPLOYMENT DATES	PAY OR SALARY
		FROM: _____ TO: _____	START: _____ FINAL: _____
YOUR LAST JOB TITLE: _____			

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MAY WE CONTACT YOUR PRESENT EMPLOYER? YES NO

DID YOU COMPLETE THIS APPLICATION YOURSELF? YES NO

IF NOT, WHO DID? _____

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MILITARY

HAVE YOU EVER BEEN IN THE ARMED FORCES? YES NO

ARE NOW A member OF THE NATIONAL GUARD? YES NO

SPECIALTY _____ DATE ENTERED _____ DISCHARGE DATE _____

PLEASE READ CAREFULLY

APPLICATION FORM WAIVER

In exchange for the consideration of my job application by ST Dominic Home Health inc. (hereinafter called “the company”), I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefits plans, policy statements, and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of ST Dominic Home Health inc, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the President/General manager of the Company. Both the undersigned and ST Dominic Home Health Inc, may end employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any previous notice. I hereby give the Company permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Company from any liability as a result of such contract.

I also understand that (1) the Company has a drug and alcohol policy that provides for pre-employment testing as well as testing after employment; (2) consent to and compliance with such policy is a condition of my employment; and (3) continued employment is based in the successful passing of testing under such policy. I further understand that continued employment may be based on the successful passing of job related physical examinations.

I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics, and mode of living. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report request by it, as required by Fair Credit Reporting Act.

I further understand that my employment with the Company shall be probationary for a period of sixty (60) days, and further that at anytime the probationary period or thereafter, my employment relation with the Company is terminable at will for any reason by either party.

Signature of applicant: _____ Date: _____

This Company is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regards to race, color, religion, sex, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with this company depends solely on your qualifications.

Thank you for completing this application form and for your interest in our business.